		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0045245

Facility Name: Prairie Rose Health Care Center

Address: 900 S. Chestnut Street (Number) Pana (City) 62557 (Zip Code)

County: Christian

Telephone Number: (217) 562-3996 **Fax #** (217) 562-4005

IDPA ID Number: 431710785001

Date of Initial License for Current Owners: 01/01/00

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	X	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501(c)(3)			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: Christine A. Hanover **Telephone Number:** (312) 384-6000
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin and Glasser LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 384-6000 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	121	Skilled (SNF)	121	44,286	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	121	TOTALS	121	44,286	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			3,146	3,146	8
9	SNF/PED					9
10	ICF	22,281	3,643		25,924	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,281	3,643	3,146	29,070	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.64%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 3/1/1995

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 3/1/1995 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 25 and days of care provided 3,146

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7**	8	9	10	
1	Dietary	138,580	13,712	12,891	165,183		165,183	6,331	171,514			1
2	Food Purchase		121,646		121,646		121,646	(3,890)	117,756			2
3	Housekeeping	75,153	10,614		85,767		85,767	26	85,793			3
4	Laundry	39,625	11,925		51,550		51,550		51,550			4
5	Heat and Other Utilities			98,611	98,611		98,611	574	99,185			5
6	Maintenance	21,074	10,248	18,695	50,017		50,017	3,954	53,971			6
7	Other (specify):* Mgmt. Co. Benefits							1,132	1,132			7
8	**TOTAL General Services**	274,432	168,145	130,197	572,774		572,774	8,127	580,901			8
	B. Health Care and Programs											
9	Medical Director			19,951	19,951		19,951		19,951			9
10	Nursing and Medical Records	944,766	149,616	7,331	1,101,713		1,101,713	13,907	1,115,620			10
10a	Therapy	59,207	322	163,945	223,474		223,474	5	223,479			10a
11	Activities	27,522	1,917	1,457	30,896		30,896	6	30,902			11
12	Social Services	59,724	91		59,815		59,815		59,815			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):* Mgmt. Co. Benefits							1,344	1,344			15
16	**TOTAL Health Care and Programs**	1,091,219	151,946	192,684	1,435,849		1,435,849	15,262	1,451,111			16
	C. General Administration											
17	Administrative	61,654		210,401	272,055		272,055	(132,727)	139,328			17
18	Directors Fees											18
19	Professional Services			102,561	102,561		102,561	7,992	110,553			19
20	Dues, Fees, Subscriptions & Promotions			4,316	4,316		4,316	162	4,478			20
21	Clerical & General Office Expenses	28,370	6,920	27,952	63,242		63,242	47,994	111,236			21
22	Employee Benefits & Payroll Taxes			266,491	266,491		266,491		266,491			22
23	Inservice Training & Education			455	455		455	800	1,255			23
24	Travel and Seminar			256	256		256	1,699	1,955			24
25	Other Admin. Staff Transportation			2,800	2,800		2,800	3,265	6,065			25
26	Insurance-Prop.Liab.Malpractice			74,532	74,532		74,532	1,142	75,674			26
27	Other (specify):* Mgmt. Co. Benefits							13,175	13,175			27
28	**TOTAL General Administration**	90,024	6,920	689,764	786,708		786,708	(56,498)	730,210			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,455,675	327,011	1,012,645	2,795,331		2,795,331	(33,109)	2,762,222			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.** SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Prairie Rose Health Care Center #0045245 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			143,766	143,766		143,766	5,658	149,424			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			230,631	230,631		230,631	4,119	234,750			32
33	Real Estate Taxes			39	39		39	381	420			33
34	Rent-Facility & Grounds							3,276	3,276			34
35	Rent-Equipment & Vehicles			57,735	57,735		57,735	115	57,850			35
36	Other (specify):* **MIP Insurance**											36
37	**TOTAL Ownership**			432,171	432,171		432,171	13,549	445,720			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		102,826	1,595	104,421		104,421		104,421			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			66,429	66,429		66,429		66,429			42
43	Other (specify):* **Nonallowable Costs**			60,843	60,843		60,843	(60,843)				43
44	**TOTAL Special Cost Centers**		102,826	128,867	231,693		231,693	(60,843)	170,850			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,455,675	429,837	1,573,683	3,459,195		3,459,195	(80,403)	3,378,792			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 01/01/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,892)	2		4
5	Telephone, TV & Radio in Resident Rooms	(825)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(2,347)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(269)	43		18
19	Entertainment				19
20	Contributions	(209)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(6,038)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(48,845)	43		24
25	Fund Raising, Advertising and Promotional	(2,991)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(8,206)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (73,622)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(6,781)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (6,781)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (80,403)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Prairie Rose Health Care Center

ID# 0045245

Report Period Beginning: 01/01/04

Ending: 12/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Medicare labs	$ (6,882)	43	1
2	Special events	(822)	43	2
3	Dues	(463)	20	3
4	Non-care related real estate tax	(39)	33	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(8,206)		49

Prairie Rose Health Care Center
Provider #: 0045245
01/01/04 to 12/31/04 **Schedule 5A**

VI. Adjustment Detail
Line 29 - Other

Non-allowable expenses	Amount	Reference

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	6,331	0	0	0	0	0	0	0	0	0	6,331	1
2	Food Purchase	(3,892)	2	0	0	0	0	0	0	0	0	0	(3,890)	2
3	Housekeeping	0	26	0	0	0	0	0	0	0	0	0	26	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	574	0	0	0	0	0	0	0	0	0	574	5
6	Maintenance	0	3,954	0	0	0	0	0	0	0	0	0	3,954	6
7	Other (specify):*	0	1,132	0	0	0	0	0	0	0	0	0	1,132	7
8	**TOTAL General Services**	(3,892)	12,019	0	0	0	0	0	0	0	0	0	8,127	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	13,907	0	0	0	0	0	0	0	0	0	13,907	10
10a	Therapy	0	5	0	0	0	0	0	0	0	0	0	5	10a
11	Activities	0	6	0	0	0	0	0	0	0	0	0	6	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	1,344	0	0	0	0	0	0	0	0	0	1,344	15
16	**TOTAL Health Care and Programs**	0	15,262	0	0	0	0	0	0	0	0	0	15,262	16
	C. General Administration													
17	Administrative	0	(132,727)	0	0	0	0	0	0	0	0	0	(132,727)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(6,038)	14,030	0	0	0	0	0	0	0	0	0	7,992	19
20	Fees, Subscriptions & Promotions	(463)	625	0	0	0	0	0	0	0	0	0	162	20
21	Clerical & General Office Expenses	0	0	47,994	0	0	0	0	0	0	0	0	47,994	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	800	0	0	0	0	0	0	0	0	800	23
24	Travel and Seminar	0	0	1,699	0	0	0	0	0	0	0	0	1,699	24
25	Other Admin. Staff Transportation	0	0	3,265	0	0	0	0	0	0	0	0	3,265	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,142	0	0	0	0	0	0	0	0	1,142	26
27	Other (specify):*	0	0	13,175	0	0	0	0	0	0	0	0	13,175	27
28	**TOTAL General Administration**	(6,501)	(118,072)	68,075	0	0	0	0	0	0	0	0	(56,498)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(10,393)	(90,791)	68,075	0	0	0	0	0	0	0	0	(33,109)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	5,658	0	0	0	0	0	0	0	0	5,658	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,347)	0	6,466	0	0	0	0	0	0	0	0	4,119	32
33	Real Estate Taxes	(39)	0	420	0	0	0	0	0	0	0	0	381	33
34	Rent-Facility & Grounds	0	0	3,276	0	0	0	0	0	0	0	0	3,276	34
35	Rent-Equipment & Vehicles	0	0	115	0	0	0	0	0	0	0	0	115	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(2,386)	0	15,935	0	0	0	0	0	0	0	0	13,549	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(60,843)	0	0	0	0	0	0	0	0	0	0	(60,843)	43
44	**TOTAL Special Cost Centers**	(60,843)	0	0	0	0	0	0	0	0	0	0	(60,843)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(73,622)	(90,791)	84,010	0	0	0	0	0	0	0	0	(80,403)	45

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark Petersen	100	See attached Schedule 6A		See Attached Schedule 6A		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	$	Petersen Health Care, Inc.	100.00%	$ 6,331	$ 6,331	1
2	V	2	Food		Petersen Health Care, Inc.	100.00%	2	2	2
3	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	26	26	3
4	V	5	Utilities		Petersen Health Care, Inc.	100.00%	574	574	4
5	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	3,954	3,954	5
6	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,132	1,132	6
7	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	13,907	13,907	7
8	V	10A	Therapy		Petersen Health Care, Inc.	100.00%	5	5	8
9	V	11	Activities		Petersen Health Care, Inc.	100.00%	6	6	9
10	V	15	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,344	1,344	10
11	V	17	Administrative	210,401	Petersen Health Care, Inc.	100.00%	77,674	(132,727)	11
12	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	14,030	14,030	12
13	V	20	Dues, Fees, Subs & Promos		Petersen Health Care, Inc.	100.00%	625	625	13
14	Total			$ 210,401			$ 119,610	$ * (90,791)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	Clerical & General Office	$	Petersen Health Care, Inc.	100.00%	$ 47,994	$ 47,994	15
16	V	23	Inservice Training & Education		Petersen Health Care, Inc.	100.00%	800	800	16
17	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	1,699	1,699	17
18	V	25	Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	3,265	3,265	18
19	V	26	Insurance-Prop.Liab.Malpractice		Petersen Health Care, Inc.	100.00%	1,142	1,142	19
20	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	13,175	13,175	20
21	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	5,658	5,658	21
22	V	32	Interest		Petersen Health Care, Inc.	100.00%	6,466	6,466	22
23	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	420	420	23
24	V	34	Rent - Facility & Grounds		Petersen Health Care, Inc.	100.00%	3,276	3,276	24
25	V	35	Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	115	115	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 84,010	$ * 84,010	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Prairie Rose Health Care Center
0045245
12/31/2004

Schedule 6A

VII Related Parties - Page 6

Related Nursing Homes	City
In-State:	
Arcola Health Care Center	Arcola, IL
Bement Health Care Center	Bement, IL
Casey Health Care Center	Casey, IL
Countryview Terrace	Louisville, IL
Eastview Terrace	Sullivan, IL
El Paso Health Care Center	El Paso, IL
Flora Health Care Center	Flora, IL
Havana Health Care Center	Havana, IL
Kewanee Care Home	Kewanee, IL
Palm Terrace of Mattoon	Mattoon, IL
Prairie Rose Health Care Center	Pana, IL
Robings Manor Nursing Home	Brighton, IL
Royal Oaks Care Center	Kewanee, IL
Sheldon Health Care Center	Sheldon, IL
Sullivan Health Care Center	Sullivan, IL
Sunset Manor Nursing Home	Canton, IL
Tuscola Health Care Center	Tuscola, IL
Out-of-State:	
Meadow Lawn Nursing Center	Davenport, IA

Related Assisted Living	
Kewanee Courtyard Estates	Kewanee, IL
Kewanee Courtyard Village	Kewanee, IL
Monmouth Courtyard Estates	Monmouth, IL

Other Related Business Entities		
Petersen Health Care, Inc.	Peoria, IL	Management/Bookkeeping
Petersen Health Care II, Inc.	Peoria, IL	Management/Bookkeeping
Petersen Enterprises	Peoria, IL	Management/Bookkeeping
Petersen Health Systems	Peoria, IL	Management/Bookkeeping
RLP Senior Villages, Inc.	Peoria, IL	Management/Bookkeeping

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Mark Petersen	President	Administrative	100.00	1,015,315	3.5	7.00	Salary	$ 77,674	L17,C7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 77,674		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Prairie Rose Health Care Center
0045245
12/31/2004

Schedule 7A

VII. Related Parties
C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors

Name	Arcola Health Care Center	Bement Health Care Center	Casey Health Care Center	Countryview Terrace	Eastview Terrace	El Paso Health Care Center	Flora Health Care Center	Havana Health Care Center	Kewanee Care Center	Meadow Lawn Nursing Center	Palm Terrace of Mattoon	Prairie Rose Health Care Center	Robings Manor Nursing Home	Royal Oaks Care Center	Sheldon Health Care Center	Sullivan Health Care Center	Sunset Manor Nursing Home	Tuscola Health Care Center	TOTAL
Mark Petersen	90,072	55,013	25,865	15,145	58,361	74,717	10,659	72,956	69,335	54,095	111,582	77,674	64,047	91,387	33,271	68,050	101,105	19,655	1,092,989

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Petersen Health Care Companies
Street Address: 7218 North Villa Lake
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 691-8113
Fax Number: (309) 691-8622

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Patient Days	409,056	18	$ 89,079	$ 89,071	29,070	$ 6,331	1
2	2	Food	Patient Days	409,056	18	33		29,070	2	2
3	3	Housekeeping	Patient Days	409,056	18	372		29,070	26	3
4	5	Utilities	Patient Days	409,056	18	8,082		29,070	574	4
5	6	Maintenance	Patient Days	409,056	18	55,644	49,773	29,070	3,954	5
6	7	Mgmt. Allocation of Benefits	Patient Days	409,056	18	15,931		29,070	1,132	6
7	10	Nursing and Medical Records	Patient Days	409,056	18	195,694	164,789	29,070	13,907	7
8	10A	Therapy	Patient Days	409,056	18	75		29,070	5	8
9	11	Activities	Patient Days	409,056	18	86		29,070	6	9
10	15	Mgmt. Allocation of Benefits	Patient Days	409,056	18	18,908		29,070	1,344	10
11	17	Administrative	Patient Days	409,056	18	1,092,989	1,092,989	29,070	77,674	11
12	19	Professional Services	Patient Days	409,056	18	197,418		29,070	14,030	12
13	20	Dues, Fees, Subs & Promos	Patient Days	409,056	18	8,792		29,070	625	13
14	21	Clerical & General Office	Patient Days	409,056	18	675,343	522,789	29,070	47,994	14
15	23	Inservice Training & Education	Patient Days	409,056	18	11,260		29,070	800	15
16	24	Travel and Seminar	Patient Days	409,056	18	23,910		29,070	1,699	16
17	25	Other Admin. Staff Transport.	Patient Days	409,056	18	45,949		29,070	3,265	17
18	26	Insurance-Prop.Liab.Mal.	Patient Days	409,056	18	16,073		29,070	1,142	18
19	27	Mgmt. Allocation of Benefits	Patient Days	409,056	18	185,395		29,070	13,175	19
20	30	Depreciation	Patient Days	409,056	18	79,620		29,070	5,658	20
21	32	Interest	Patient Days	409,056	18	90,987		29,070	6,466	21
22	33	Real Estate Taxes	Patient Days	409,056	18	5,910		29,070	420	22
23	34	Rent - Facility & Grounds	Patient Days	409,056	18	46,102		29,070	3,276	23
24	35	Rent - Equipment & Vehicles	Patient Days	409,056	18	1,612		29,070	115	24
25	TOTALS					$ 2,865,264	$ 1,919,411		$ 203,620	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	AMI Capital, Inc.		X	Mortgage	$21,167.65	12/1/02	$ 3,580,869	$ 3,508,332	11/2035	0.0618	$ 217,845	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$21,167.65		$ 3,580,869	$ 3,508,332			$ 217,845	9
	B. Non-Facility Related*											
10								Amortization expense			12,786	10
11								Offset interest income			(2,347)	11
12												12
13								Allocated from Home Office			6,466	13
14	TOTAL Non-Facility Related						$	$			$ 16,905	14
15	TOTALS (line 9+line14)						$ 3,580,869	$ 3,508,332			$ 234,750	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$	N/A	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **Home Office Allocation**		420	
TOTAL REFUND $ For Tax Year. **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	420	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1999	8
	2000	9
	2001	10
	2002	11
	2003	12

Entity is a not-for-profit and does not pay real estate tax.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Prairie Rose Health Care Center COUNTY Christian

FACILITY IDPH LICENSE NUMBER 0045245

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE (309) 691-8113 FAX #: (309) 691-8622

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	N/A		$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2004

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 01/01/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,000 B. General Construction Type: Exterior Brick & Block Frame Wood Number of Stories One

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	28,000	1995	$ 13,500	1
2					2
3	TOTALS	28,000		$ 13,500	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	121		1995	1976	$ 1,068,665	$ 35,622	30	$ 35,622	$	$ 350,284	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	1986 Additions			1986	970,363	32,345	30	32,345		584,912	9
10	1987 Additions			1987	110,922	3,825	29	3,825		67,497	10
11	1989 Additions			1989	2,219		10			2,219	11
12	1990 Additions			1990	4,295	143	30	143		3,958	12
13	1991 Additions			1991	134,283		7			134,283	13
14	1992 Additions			1992	17,130		7			17,130	14
15	1993 Additions			1993	24,239		7			24,239	15
16	1994 Additions			1994	10,559		7			10,559	16
17	1995 Additions			1995	14,617	974	15	974		9,650	17
18	1996 Additions			1996	305,057	25,421	12	25,421		(134,395)	18
19	1997 Additions			1997	23,542	2,354	10	2,354		16,764	19
20	Whirlpool bath			1998	9,120	912	10	912		6,384	20
21	Lift, bath trolley			1998	3,850	385	10	385		2,695	21
22	Shower room			1998	4,884	489	10	489		3,379	22
23	Entrance doors			1998	2,358	118	20	118		737	23
24	Curtains			1998	6,102		5			6,102	24
25	Sidewalk & pad			1999	1,484	99	15	99		553	25
26	Divide receipts on emergency generator			1999	2,397	120	20	120		660	26
27	Med room cabinets, counter top			1999	2,008	100	20	100		501	27
28	Heat/Cool			2000	1,876	268	7	268		1,161	28
29	Door alarms			2001	1,215	81	15	81		297	29
30	Dining room, living room, shower remode			2001	94,315	3,144	30	3,144		11,242	30
31	Wooded doors			2001	1,900	127	15	127		392	31
32	Landscaping - renovation project			2001	1,174	117	10	117		419	32
33	Bituminous parking lot			2001	22,030	2,754	8	2,754		8,491	33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Replace plumbing fixtures	2002	$ 2,490	$ 125	20	$ 125	$	$ 375	37
38	Therapy room remodel	2002	5,617	281	20	281		843	38
39	Remodel medication/utility rooms	2002	7,909	395	20	395		1,185	39
40	2 heating/cooling rooftop units	2002	11,300	1,130	10	1,130		3,390	40
41	Breakroom remodel	2002	3,106	311	10	311		933	41
42	Exterior window covering	2002	7,650	1,093	7	1,093		3,279	42
43	Lights for therapy room	2002	805	81	10	81		243	43
44	Renovation on facility floors and walls	2002	36,842	1,842	20	1,842		5,526	44
45									45
46	Fire Supression System	2004	1,540	13	10	13		13	46
47	Antenna	2004	2,944	245	10	245		245	47
48	Sign	2004	1,200	40	10	40		40	48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,922,007	$ 114,954		$ 114,954	$	$ 1,146,185	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 651,936	$ 27,809	$ 27,809	$	5-15 years	$ 617,915	71
72	Current Year Purchases	22,394	1,003	1,003		3-10 years	1,395	72
73	Fully Depreciated Assets							73
74	Allocated from Home Office			5,658	5,658			74
75	TOTALS	$ 674,330	$ 28,812	$ 34,470	$ 5,658		$ 619,310	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	Van	1994	$ 27,905	$	$	$	7	$ 27,905	76
77										77
78										78
79										79
80	TOTALS			$ 27,905	$	$	$		$ 27,905	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,637,742	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 143,766	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 149,424	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 5,658	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,793,400	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	N/A	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 01/01/04 Ending: 12/31/04

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6	Allocated from Home Office				3,276			6
7	TOTAL				$ 3,276 **			7

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized N/A
by the length of the lease N/A .

9. Option to Buy: ☐ YES ☐ NO Terms: N/A *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 57,850 Description: Nursing equipment - 52,565; Copier - 4,056; Dietary equipment - 1,114; Home office allocation - 115
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18			N/A		18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES [X] NO
   It is the policy of this facility to only hire certified nurses aides.
   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A(3)	hrs	$	1,270	$ 63,481	$	1,270	$ 63,481	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		538	26,879		538	26,879	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), (3)	hrs		1,226	73,585	322	1,226	73,907	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				22,060		22,060	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Schedule 16A	See Sch 16A	Sch 16A hrs	59,207		1,595	80,766		141,568	13
14	TOTAL			$ 59,207	3,034	$ 165,540	$ 103,148	3,034	$ 327,895	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Prairie Rose Health Care Center
Provider #: 0045245
01/01/04 to 12/31/04 **Schedule 16A**

XIV. Special Services
Line 13 Other (specify):

Service	Line Reference	Hours	Wages	Outside Practioner Units	Cost	Supplies
Respiratory Therapists	39(1)	3,359	59,207			
Oxygen	39(2)					80,766
Ambulance	39(3)				1,595	
		3,359	59,207	-	1,595	80,766

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 01/01/04 Ending: 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 82,609	$ 82,609	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 30,000)	745,140	745,140	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	61,173	61,173	6
7	Other Prepaid Expenses	16,518	16,518	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Utility deposits	2,106	2,106	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 907,546	$ 907,546	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	13,500	13,500	13
14	Buildings, at Historical Cost	2,831,711	2,922,007	14
15	Leasehold Improvements, at Historical Cost	23,204		15
16	Equipment, at Historical Cost	828,071	702,235	16
17	Accumulated Depreciation (book methods)	(1,785,113)	(1,793,400)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (sp Financing costs	387,838	387,838	22
23	Other(specify): See Schedule 17A	513,733	513,733	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,812,944	$ 2,745,913	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,720,490	$ 3,653,459	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 589,066	$ 589,066	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	38,269	38,269	29
30	Accrued Salaries Payable	125,997	125,997	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	18,068	18,068	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	29,257	29,257	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 800,657	$ 800,657	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,470,063	3,470,063	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due to Tutera	458,743	458,743	43
44	Intercompany Liability	301,000	301,000	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 4,229,806	$ 4,229,806	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,030,463	$ 5,030,463	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,309,973)	$ (1,377,004)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,720,490	$ 3,653,459	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Prairie Rose Health Care Center
Provider #: 0045245
01/01 to 12/31/04

Schedule 17A

XV. Balance Sheet. SUPPORT SCHEDULE

	Operating	After Consolidation
Line 23 - Other		
Replacement & Reserve Fund	242,328	242,328
Project Fund - Insurance	24,811	24,811
Completion Repair	228,907	228,907
MIP Reserve	17,687	17,687
	513,733	513,733
Line 36 - Other Current Liabilities		
Resident Trust Deposits	26,929	26,929
401(k) Withholding	1,841	1,841
All State Withholdings	487	487
	29,257	29,257

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,457,100)	1
2	Restatements (describe):		2
3	**Prior period adjustments**	43,436	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,413,664)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	103,691	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 103,691	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,309,973)	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,663,818	1
2	Discounts and Allowances for all Levels	(236,719)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,427,099	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	399,340	6
7	Oxygen	178,039	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 577,379	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	3,892	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	182,204	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	50,676	19
20	Radiology and X-Ray	32	20
21	Other Medical Services	317,680	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 554,484	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,347	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,347	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Commissions	584	28
28a	Miscellaneous Revenue	993	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,577	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,562,886	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	572,774	31
32	Health Care	1,435,849	32
33	General Administration	786,708	33
	B. Capital Expense		
34	Ownership	432,171	34
	C. Ancillary Expense		
35	Special Cost Centers	165,264	35
36	Provider Participation Fee	66,429	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,459,195	40
41	**Income before Income Taxes (line 30 minus line 40)****	103,691	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 103,691	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,080	$ 50,000	$ 24.04	1
2	Assistant Director of Nursing	1,280	1,280	23,353	18.24	2
3	Registered Nurses	2,598	2,979	70,375	23.62	3
4	Licensed Practical Nurses	21,471	22,823	318,581	13.96	4
5	Nurse Aides & Orderlies	55,984	58,490	454,635	7.77	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	3,359	3,369	59,207	17.57	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,046	2,086	22,000	10.55	9
10	Activity Assistants	720	780	5,522	7.08	10
11	Social Service Workers	3,568	3,568	59,724	16.74	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	28,964	13.93	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,056	13,964	109,616	7.85	15
16	Dishwashers					16
17	Maintenance Workers	1,788	1,788	21,074	11.79	17
18	Housekeepers	10,649	11,305	75,153	6.65	18
19	Laundry	3,054	3,182	39,625	12.45	19
20	Administrator	2,080	2,080	61,654	29.64	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,268	2,444	28,370	11.61	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Ca: Care Plan Coord	2,080	2,080	27,822	13.38	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	130,161	136,378	$ 1,455,675 *	$ 10.67	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 12,891	1(3)	35
36	Medical Director	Monthly	19,951	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	600	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Rehab Consultant	225	6,731	10(3)	46
47					47
48					48
49	TOTAL (lines 35 - 48)	225	$ 40,173		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Margaret J. West	Administrator	0	$ 61,654
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 61,654

B. Administrative - Other

Description	Amount
Management Fees (eliminated in column 7)	$ 210,401
TOTAL (agree to Schedule V, line 17, col. 3)	$ 210,401
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Bush & Snyder Assoc.	Legal	$ 6,281
Heyl Royster, Voelker & Allen	Legal	5,143
Brown & James	Legal	6,747
Evanston Insurance Co.	Legal	14,984
Ginoli & Co.	Accounting	34,046
Altschuler, Melvoin & Glasser	Accounting	7,725
BKD	Accounting	13,152
See Schedule 17A	Computer Services	14,483
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 102,561

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 58,585
Unemployment Compensation Insurance	30,204
FICA Taxes	105,526
Employee Health Insurance	56,483
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Life Insurance	566
Employee Relations	12,972
401(k) Matching	2,155
TOTAL (agree to Schedule V, line 22, col.8)	$ 266,491

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	939
Health Care Worker Background Check	
(Indicate # of checks performed 46)	550
Illinois Health Care Association dues	545
Miscellaneous dues and subscriptions	804
Miscellaneous License and Permits	1,478
Allocated from Home Office	625
Less: Public Relations Expense	(463)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,478

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	147
Seminar Expense	109
Allocated from Home Office	1,699
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,955

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Prairie Rose Health Care Center
Provider #: 0045245
01/01/04 to 12/31/04 **Schedule 21A**

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (agree to Schedule V, line 19, column 3)	102,561
Allocated from Management Company - Legal	2,294
Allocated from Management Company - Other	11,736
Less: Out-of-period expenses	(6,038)
Total (agree to Schedule V, line 19, column 8)	110,553

Computer Services

Threshold Data Technology	10,700
ADP	679
Global Exchange Services	256
Byte Size Computer	657
McKesson Medical	800
LTC Solutions	1,320
Shelby Electric Cooperative	71
	14,483

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2								N/A					
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Rose Health Care Center # 0045245 Report Period Beginning: 01/01/04 Ending: 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association - 545**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **No** If YES, have these costs
been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **6.5 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **7,993** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **66,429**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **N/A** Has any meal income been offset against
related costs? **Yes** Indicate the amount. $ **3,892**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **BKD** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **No** If no, please explain. **Audit currently in progress.**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	138,580	13,712	12,891	165,183	0	165,183	6,331	171,514
2. Food Purchase	0	121,646	0	121,646	0	121,646	-3,890	117,756
3. Housekeeping	75,153	10,614	0	85,767	0	85,767	26	85,793
4. Laundry	39,625	11,925	0	51,550	0	51,550	0	51,550
5. Heat and Other Utilities	0	0	98,611	98,611	0	98,611	574	99,185
6. Maintenance	21,074	10,248	18,695	50,017	0	50,017	3,954	53,971
7. Other (specify)*	0	0	0	0	0	0	1,132	1,132
8. Total General Services	274,432	168,145	130,197	572,774	0	572,774	8,127	580,901
9. Medical Director	0	0	19,951	19,951	0	19,951	0	19,951
10. Nursing & Medical Records	944,766	149,616	7,331	1,101,713	0	1,101,713	13,907	1,115,620
10a. Therapy	59,207	322	163,945	223,474	0	223,474	5	223,479
11. Activities	27,522	1,917	1,457	30,896	0	30,896	6	30,902
12. Social Services	59,724	91	0	59,815	0	59,815	0	59,815
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	1,344	1,344
16. Total Health Care & Programs	1,091,219	151,946	192,684	1,435,849	0	1,435,849	15,262	1,451,111
17. Administrative	61,654	0	210,401	272,055	0	272,055	-132,727	139,328
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	102,561	102,561	0	102,561	7,992	110,553
20. Fees, Subscriptions & Promotion	0	0	4,316	4,316	0	4,316	162	4,478
21. Clerical & General Office	28,370	6,920	27,952	63,242	0	63,242	47,994	111,236
22. Employee Benefits & Payroll	0	0	266,491	266,491	0	266,491	0	266,491
23. Inservice Training & Education	0	0	455	455	0	455	800	1,255
24. Travel and Seminar	0	0	256	256	0	256	1,699	1,955
25. Other Admin. Staff Trans	0	0	2,800	2,800	0	2,800	3,265	6,065
26. Insurance-Prop.Liab.Malpractice	0	0	74,532	74,532	0	74,532	1,142	75,674
27. Other (specify)*	0	0	0	0	0	0	13,175	13,175
28. Total General Adminis	90,024	6,920	689,764	786,708	0	786,708	-56,498	730,210
29. Total General Administrative	1,455,675	327,011	1,012,645	2,795,331	0	2,795,331	-33,109	2,762,222
30. Depreciation	0	0	143,766	143,766	0	143,766	5,658	149,424
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	230,631	230,631	0	230,631	4,119	234,750
33. Real Estate	0	0	39	39	0	39	381	420
34. Rent - Facility & Grounds	0	0	0	0	0	0	3,276	3,276
35. Rent - Equipment & Vehicles	0	0	57,735	57,735	0	57,735	115	57,850
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	432,171	432,171	0	432,171	13,549	445,720
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	102,826	1,595	104,421	0	104,421	0	104,421
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	66,429	66,429	0	66,429	0	66,429
43. Other (specify):*	0	0	60,843	60,843	0	60,843	-60,843	0
44. Total Special Cost Ce	0	102,826	128,867	231,693	0	231,693	-60,843	170,850
45. Grand Total	1,455,675	429,837	1,573,683	3,459,195	0	3,459,195	-80,403	3,378,792

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	82,609	82,609
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	745,140	745,140
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	61,173	61,173
7. Other Prepaid Expenses	16,518	16,518
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	2,106	2,106
10. Total current assets	907,546	907,546
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	13,500	13,500
14. Buildings, at Historical Cost	2,831,711	2,922,007
15. Leasehold Improvements, Historical Cost	23,204	0
16. Equipment, at Historical Cost	828,071	702,235
17. Accumulated Depreciation (book methods)	-1,785,113	-1,793,400
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	387,838	387,838
23. other (specify):	513,733	513,733
24. Total Long-Term Assets	2,812,944	2,745,913
25. Total Assets	3,720,490	3,653,459
CURRENT LIABILITIES		
26. Accounts Payable	589,066	589,066
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	38,269	38,269
30. Accrued Salaries Payable	125,997	125,997
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	18,068	18,068
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	29,257	29,257
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	800,657	800,657
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	3,470,063	3,470,063
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	759,743	759,743
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	4,229,806	4,229,806
46.Total Liabilities	5,030,463	5,030,463
47.Total Equity	-1,309,973	-1,377,004
48.Total Liabilities and Equity	3,720,490	3,653,459

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	2,663,818
2. Discounts and Allowances for all Levels	-236,719
Subtotal - Inpatient Care	2,427,099
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	399,340
7. Oxygen	178,039
Subtotal - Anciliary Revenue	577,379
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	3,892
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	182,204
18. Sale of Supplies to Non-Patients	0
19. Laboratory	50,676
20. Radiologyand X-Ray	32
21. Other Medical Services	317,680
22. Laundry	0
Subtotal - Other Operating Revenue	554,484
24. Contributions	0
25. Interest and Other Investments Income	2,347
Subtotal - Non-Operating Revenue	2,347
27. Other Revenue (specify):	0
28. Other Revenue (specify):	1,577
Subtotal - Other Revenue	1,577
30. Total Revenue	3,562,886
31. General Services	572,774
32. Health Care	1,435,849
33. General Administration	786,708
34. Ownership	432,171
35. Special Cost Centers	165,264
35. Provider Participation Fee	66,429
37. Other	0
40. Total Expenses	3,459,195
41. Income Before Income Taxes	103,691
42. Income Taxes	0
43. Net Income or Loss for the Year	103,691

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